DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-149A (Rev. 02/2003)

STATE OF WISCONSIN

FAMILY HISTORY QUESTIONNAIRE
MEDICAL / GENETIC - PREGNANCY AND DELIVERY INFORMATION

USE BLACK INK ONLY

Use of form: This form should be completed by the BIRTH MOTHER. Completion of this form meets the requirements of s. 48.425(1)(am), Wis. Stats. Personally identifiable information on this form is confidential and will be used only for identification purposes.

Instructions: After completion, this form must be attached to and submitted with the "Family History Questionnaire - Medical / Genetic," form CFS-149. If additional space is needed when completing this form, attach separate sheet(s). If you have questions regarding this form, call (608) 266-7163.

Name - Child (Last, First, MI)	Birthdate - Child (mm/dd/yyyy)

SECTION I PREGNANCY INFORMATION

1. When did you first suspect you were pregnant with this child?

2. When was this pregnancy confirmed by a pregnancy test?

3. ☐ Yes ☐ No Did you receive prenatal care during this pregnancy? If "Yes", when did prenatal care begin? _____

4. ☐ Yes ☐ No Did you gain weight during this pregnancy? If "Yes", number of pounds? _____

5. ☐ Yes ☐ No Did you lose weight during this pregnancy? If "Yes", number of pounds? _____

6. ☐ Yes ☐ No Were you hospitalized during this pregnancy? If "Yes", list hospitalizations, reasons and dates below.

a. Hospitalization	Reason(s)	Dates(s)
b. Hospitalization	Reason(s)	Dates(s)
c. Hospitalization	Reason(s)	Dates(s)

7. ☐ Yes ☐ No Did you take medication during this pregnancy? (Include prescription and over-the-counter or nonprescription drugs.) If "Yes", list them below.

a. Name - Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity
b. Name - Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity
c. Name - Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity
d. Name - Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity

8. ☐ Yes ☐ No Did you smoke cigarettes during this pregnancy? If "Yes", number per day? _____

9. ☐ Yes ☐ No Were you exposed to unusual fumes or other chemicals during this pregnancy (fumes from workplace, hobbies, etc.)? If "Yes", explain; give examples and dates.

10. ☐ Yes ☐ No Did you consume alcoholic beverages during this pregnancy?
If "Yes", specify what kind of alcohol; i.e., beer, wine, liquor, combination. _____

Drinking Pattern - Complete for each trimester.	1st Trimester (1-3 months)	2nd Trimester (4-6 months)	3rd Trimester (7-9 months)
☐ Binges - Indicate quantity and frequency.			
☐ Daily - Indicate quantity.			
☐ Other - Occasional; e.g., weekends. Indicate quantity and frequency.			

11. ☐ Yes ☐ No Were you exposed to X-rays during this pregnancy, including dental X-rays? If "Yes", specify when and what body part(s).

12. ☐ Yes ☐ No Were you exposed to other forms of radiation during this pregnancy; e.g., occupational exposure, barium enema / swallow? If "Yes", identify radiation source and dates.

13. During your pregnancy with this child did you have:

☐ Yes ☐ No a. Preeclampsia or hypertension
☐ Yes ☐ No b. High blood pressure
☐ Yes ☐ No c. Low blood pressure
☐ Yes ☐ No d. Albumin or protein in the urine
☐ Yes ☐ No e. Diabetes or sugar in your urine
☐ Yes ☐ No f. A urinary infection, strange odor or color in your urine
☐ Yes ☐ No g. Any vaginal bleeding. If "Yes", specify when and for how long. _____
☐ Yes ☐ No h. Morning sickness. If "Yes", specify when and for how long. _____
☐ Yes ☐ No i. Any immunizations during pregnancy or three months before. If "Yes", specify type: _____
☐ Yes ☐ No j. Any irregular nutrition patterns (special diets). If "Yes", describe: _____
☐ Yes ☐ No k. Fever. If "Yes", specify how high and duration: _____
☐ Yes ☐ No l. Unexplained rashes and / or infections. If "Yes", specify when: _____
☐ Yes ☐ No m. Illness; i.e., chicken pox, mumps, German measles.
If "Yes", specify illness and when: _____

14. Your Rh factor is: ☐ Negative ☐ Positive

15. The father's Rh factor is: ☐ Negative ☐ Positive

16. Medical tests administered during this pregnancy

Check "Yes" or "No" if you were tested for the following.	Date of Test (mm/dd/yyyy)	Test Results
☐ Yes ☐ No VDRL (syphilis)		
☐ Yes ☐ No Cult / smear (gonorrhea)		
☐ Yes ☐ No Pap smear		
☐ Yes ☐ No Tuberculosis skin test		
☐ Yes ☐ No Herpes		
Other sexually transmitted disease tests taken - Specify below.		

17. ☐ Yes ☐ No Is this your first pregnancy? If "No", complete the following.

a. Number of past pregnancies, including this one _____

b. Number of live births, including this one _____

c. Number of abortions _____

d. Number of miscarriages _____

Cause of miscarriage(s), if known _____

e. Number of stillbirths _____

f. ☐ Yes ☐ No Were there complications with the other pregnancies?

g. ☐ Yes ☐ No Are all the previous live-born children currently living? If "No", age(s) of child(ren) at death: _____

Cause of death: _____

SECTION II DELIVERY INFORMATION

1. ☐ Yes ☐ No Was the delivery vaginal?

2. ☐ Yes ☐ No Were instruments used to assist the delivery?

3. ☐ Yes ☐ No Was the delivery by caesarian section? If "Yes", what complications led to caesarian? _____

4. How long was the labor? 1st stage: _____ 2nd stage: _____ 3rd stage: _____

5. How soon before birth did the membranes break? _____

6. ☐ Yes ☐ No Did you receive any anesthesia, painkiller or drug to start labor? If "Yes", specify what kind: _____

7. The child was: ☐ Premature by _____ weeks. ☐ Post-mature by _____ weeks.

8. ☐ Yes ☐ No Were there complications with the delivery? If "Yes", specify what kind: _____

9. The baby was born: ☐ Feet first (breech) ☐ Head first

10. ☐ Yes ☐ No Was resuscitation or help with breathing required for the child at birth?

11. ☐ Yes ☐ No Was the child jaundiced (yellow) at birth?

12. ☐ Yes ☐ No Was a heart murmur detected at birth?

13. ☐ Yes ☐ No Were any other problems noted AT birth; e.g., any birth defects or handicapping conditions? If "Yes", specify.

14. ☐ Yes ☐ No Were any other problems noted AFTER birth; e.g., any birth defects or handicapping conditions? If "Yes", specify.

15. Consult the hospital record if the data in Item 15 is not known by the parents.
    a. Birth weight _____
    b. Birth length _____
    c. Head circumference _____
    d. APGAR rating: One minute: _____ Five minutes: _____
    e. New born screening:

	Positive	Negative
☐ PKU	☐	☐
☐ Maple syrup urine disease	☐	☐
☐ Galactosemia	☐	☐
☐ Hypothryoidism	☐	☐

16. ☐ Yes ☐ No Was more than one (1) baby born at this birth? If "Yes":
    a. How many? _____
    b. Birth order of this child? _____
    c. Condition of other baby(s) born during this birth - Specify.

NOTE: IF YOU OR THE AGENCY HAVE ADDITIONAL INFORMATION, ADD SEPARATE SHEETS TO ACCOMPANY THIS FORM.

SECTION III DISCLOSURE INFORMATION

I authorize the agency assisting in preparing this document to disclose the medical and genetic information in this document to the Circuit Court and to the Wisconsin Department of Health and Family Services for use in preparing and maintaining the medical and genetic history required by law concerning my birth child named on page 1.

Name - Birth Mother (Print) | Address - (Street, City, State, Zip Code (Print) | Telephone Number

SIGNATURE - Birth Mother | Date Signed (mm/dd/yyyy)